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NHC HEALTHCARE, COOKEVILLE	815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess one resident (#15) of nineteen residents reviewed for the use of a click release seatbelt. The findings included: Resident #15 was admitted to the facility on February 4, 2010, with diagnoses including Left Sided Hemiplegia, Muscle Weakness, Neuropathy, and Cerebrovascular Disease. Medical record review of the Minimum Data Set dated May 13, 2011, revealed the resident to be cognitively intact, with a score of 15 (out of a possible total of 15), on the "Brief Interview for Mental Status." Continued review revealed the resident to be non-ambulatory and required extensive assistance for transfers, bed mobility, and most activities of daily living. Further review revealed the resident used an electric wheelchair as a mobility device. Medical record review of the resident's record revealed no documentation of an assessment for the use of a click release seatbelt when in the wheelchair.	F 221	Begin POC F 221 1. Corrected actions accomplished for the resident(s) found to have been affected by the deficient practice. A written assessment was performed by the Charge Nurse on resident #15 on June 23, 2011 and placed in the resident's medical record. The resident was able to release the seat belt upon request. 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. On June 30, 2011 the Director of Nursing oversaw a review of all residents. Those residents using seat belt releases were assessed. These assessments were completed and placed in the respective patient medical record. 3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur. On June 23, 2011 our MDS Staff were in-serviced by our Staff Education Nurse on the procedure for reviewing each patient for seat belt usage and conducting an assessment when a seat belt release is placed on a patient's wheel chair. 4. Our corrective actions will be monitored to ensure the practice will not recur. Our Director of Nurses will conduct two quarterly Quality Assurance Studies and report her respective findings to our Quality Assurance Committee in September and December 2011. The Quality Assurance Committee will determine if additional follow-up is required. End POC F 221	06/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[illegible] JONES, LNHA	ADMINISTRATOR	7/6/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 Observation of the resident on June 21, 2011, at 2:30 p.m., and June 22, 2011, at 8:30 and 9:20 a.m., revealed the resident sitting in an electric wheelchair with a click release seatbelt over the upper thigh waist area. Interview with the DON (Director of Nursing) on June 22, 2011, at 9:25 a.m., in the 400 Hall confirmed the facility failed to assess the resident for the use of the click release seatbelt.	F 221	Begin POC F 246 1. Corrected actions accomplished for the resident(s) found to have been affected by the deficient practice. Once the surveyor pointed out to our staff that a single call light had been active for an extended period of time the nursing staff immediately attended to the needs of resident #19. 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. All residents were reviewed. Because all residents use call lights we determined that every residents has the potential be affected by the same practice. We have educated all partners on the importance of promptly responding to a call light. 3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur. On June 22, 2011 our caregivers on 100 Hall were in-serviced by the Nurse Supervisor on the importance of answering call lights timely and the need to look and listen to identify if a new call light has been activated. Additionally, all center caregivers were in-serviced on the importance of answering call lights timely, this training was done under the direction of our Staff Educator and was complete June 22, 2010. 4. Our corrective actions will be monitored to ensure the practice will not recur. Our Director of Nurses will conduct two monthly Quality Assurance Studies and report her respective findings to our Quality Assurance Committee in July and August 2011. The Quality Assurance Committee will determine if additional follow-up is required. End POC F 246	06/22/2011
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure call lights were answered timely for one resident (#19) of nineteen residents reviewed. The findings included: Resident #19 was admitted to the facility on May 17, 2011, with diagnoses including Dementia, Depression, Parkinson's Disease, and Diabetes.	F 246		

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F 246	Continued From page 2 Medical record review of the Minimum Data Set dated June 8, 2011, revealed the resident scored 12 out of 15 on the BIMS (Brief Interview for Mental Status-moderately impaired cognitive status.) Observation on June 22, 2011, at 7:55 a.m., revealed the resident's call light was turned on (sounding). Continued observation revealed two CNAs (certified nursing assistant) were in the hallway passing out breakfast trays, one student CNA was in the hallway, one Registered Nurse was in the hallway standing at the medication cart, and one nurse was at the nurse's station. Further observation revealed the call light was not answered untill 8:10 a.m. (15 minutes). Interview with the Director of Nursing (DON) on June 22, 2011, at 8:15 a.m., in the DON's office, confirmed the call light was not answered timely.	F 246	Begin POC F 323 1. Corrected actions accomplished for the resident(s) found to have been affected by the deficient practice. The central supply room door was closed immediately by our Central Supply Clerk. Resident #4 was transferred with two CNAs. 2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. We have reviewed circumstances regarding why the central supply door was left opened and have made a mechanical correction to automatic door closer on July 5th, 2011. The Director of Nursing oversaw a screening of patients to determine if they were assessed appropriately, to determine if they require less assistance or more assistance. Where appropriate patients were reassessed and those assessments were place in their medical record. Our Staff Educator oversaw in-service training regarding transfers and attending patient on a bedside commode by July 5th, 2011 3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur. We conducted in-service training regarding the importance of ensuring that the central supply room door is closed when there is no one in central supply. We conducted in-service training regarding the proper transfer techniques and the importance of attending a patient on a bedside commode. This in-service training, which was overseen by our Staff Educator, for caregivers and was completed on July 5th, 2011. 4. Our corrective actions will be monitored to ensure the practice will not recur. Our Director of Nurses will conduct one monthly Quality Assurance Study regarding the Central Supply room door and two monthly studies regarding transfers and report her respective findings to our Quality Assurance Committee in July and August 2011. The Quality Assurance Committee will determine if additional follow-up is required. End POC F 323	07/05/2011
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility investigation, and interview, the facility failed to maintain a secure central supply room containing potentially hazardous items; and	F 323		

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failed to provide two person physical assistance for transfers and toileting to prevent falls for one resident (#4) of nineteen residents reviewed.

The findings included:

Observation on June 20, 2011, from 10:00-10:07 a.m., revealed the central supply door was open to the 200 hall and unattended by facility staff. Further observation of the shelves directly inside the door revealed the potentially hazardous items of safety pins, peri-wash, hand sanitizer, nail clippers, and wound cleanser. Observation revealed no residents were in the hall during the observation period. Further observation revealed a Licensed Practical Nurse walked by the open central supply room; a Certified Nurse Aide and a student nurse passing ice in the hall across from the open central supply room; and a housekeeper in the hall across from the open central supply room. Observation revealed a facility staff member pushing a cart into the central supply room at 10:07 a.m., on June 20, 2011.

Interview with the facility staff person pushing the cart into the central supply room on June 20, 2011, at 10:07 a.m., revealed the person was the Central Supply Director. Further interview with the Central Supply Director confirmed the central supply door was unlocked, open to the 200 hall and no facility staff was in attendance in the room. Further interview confirmed the central supply room contained potentially hazardous items and the door was to be closed and locked when unattended.

Resident #4 was admitted to the facility on June

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F 323	Continued From page 4 23, 2010, with diagnoses including Aftercare Left Fibular Fracture, Previous History of Falls, Difficulty Walking, Degenerative Disc Disease of Spine, Diabetes Mellitus, Dementia, and Alzheimer's Disease. Medical record review of the Minimum Data Sets dated June 30, 2010; and September 13, 2010 revealed the resident was short and long term memory impaired, had severely impaired cognition, and required extensive assistance with two plus staff member physical assistance for bed mobility, transfers, and toileting. Medical record review of the Fall Risk Assessments dated July 15, 2010; August 11, 2010; September 11, 2010 and September 13, 2010, revealed the resident was at high risk for falls. Medical record review of the Nursing Summary Report dated August 12, 2010, and September 13, 2010, revealed the resident's memory was "...not able to recall after 5 minutes. Unable to recall long past..." Further review revealed the resident had moderately impaired cognitive skills for decision making. Further review revealed the resident required two plus person physical assist for toileting and transfers. Review of the care plan initiated on July 8, 2010, and updated on September 30, 2010, revealed the resident problem of needing "...ext (extensive) to total assist of 1-2 (staff) with bed mobility and toileting; ext to total assist of 2 (staff) with transfers..." Review of a facility investigation revealed resident	F 323		

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#4 fell on August 2, 2010, at 8:00 a.m., "...while exiting commode unattended...c/o (complained of) pain LLE (left lower extremity) knee region..." Further review of the facility investigation revealed the immediate intervention initiated to prevent future falls was "attend while toileting."

Review of the left knee x-ray report dated August 2, 2010, revealed "...Arthritic disease to knee. No acute skeletal injury..."

Review of a facility investigation revealed the resident fell on September 11, 2010, at 10:30 a.m., after one Certified Nurse Aide (CNA) had transferred the resident from the bedside commode onto the wheelchair and the resident moved forward in the wheelchair seat onto the floor. Review of a written statement by the CNA attending the resident during the fall revealed "...I had just transferred (resident) to (resident) w/c (wheelchair) from BSC (bedside commode). (Resident) was sitting on edge of w/c I told (resident) to help me scoot (resident) back in the chair. Instead of going back (resident) went forward. I tried to get (resident) back in (resident) chair but had to lower (resident) to floor..." Further review of the facility investigation revealed "What was done to prevent reoccurrences?...staff instructed to use 2 CNA for all transfers..." Further review revealed the immediate intervention initiated to prevent future falls was "...teach (resident) to rise slowly from seated/lying position..." Further review revealed the resident sustained no injury as a result of the fall.

Interview with the Director of Nursing, on June 21, 2011, beginning at 2:40 p.m., in the

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F 323	Continued From page 6 conference room, confirmed the facility had not provided two plus staff physical assistance for toileting and transfers as assessed by the MDS which resulted in two falls without injury.	F 323	Begin POC F 441 1. Corrected actions accomplished for the resident(s) found to have been affected by the deficient practice. The fan was cleaned of dust immediately by the laundry employee. The commode extender because it was not in use was removed, cleaned and stored properly by the housekeeping employee.	07/05/2011
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	2. How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken. All residents were reviewed. These deficient practices do not have common correlations and therefore have the potential to affect different residents within our building. In addition to cleaning the fan we revised our cleaning schedule and have included a monthly fan inspection. On July 5, 2001 we provided in-service training, which was overseen by our Staff Educator, to all caregivers and housekeeping staff regarding proper storage of commode extenders. The Housekeeping Supervisor reviewed all extenders in use on July 5, 2011 to verify proper storage. 3. The Measures we have put in place and systematic changes we have made to ensure that the practice does not recur. The Housekeeping Supervisor conducted in-service training regarding the revised laundry cleaning schedule with our housekeeping and laundry employees this training was completed on July 5, 2011. The Housekeeping Supervisor conducted in-service training regarding the proper storage of commode extenders with our housekeeping employees this training was completed on July 5, 2011. 4. Our corrective actions will be monitored to ensure the practice will not recur. Our Housekeeping Supervisor will conduct two monthly Quality Assurance studies for laundry cleaning and one quarterly study for proper storage of commode extenders. The Quality Assurance Committee will determine if additional follow-up is required. End POC F 323	

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Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to maintain a sanitary clean room in the laundry; and failed to maintain resident equipment in a sanitary manner.

The findings included:

Observation on June 20, 2011, at 9:50 a.m., of the clean room in the laundry, revealed a wall mounted fan blowing directly onto the folding table with several stacks of clean folded linen. Further observation revealed the fan blowing onto clean clothes hanging on racks. Further observation revealed the fan blades had a heavy accumulation of blackened debris and the fan grate had debris hanging off the grate.

Interview on June 20, 2011, at 9:50 a.m., with laundry staff #1, present during the observation confirmed the fan blade and grate had debris accumulation and was blowing directly onto the folding table with stacks of clean linen and onto the racks with clean clothes, therefore contaminating the clean linen and clothes.

Observations on June 20, 2011, at 10:23 a.m., and June 22, 2011, at 9:30 a.m., of the bathroom shared by the residents in rooms 111 and 109 revealed an extender commode seat directly on the bathroom floor.

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F 441	Continued From page 8 Interview with Certified Nurse Aide #1 on June 20, 2011, at 10:25 a.m., and Licensed Practical Nurse #1 on June 22, 2011, at 9:30 a.m., in the bathroom shared by the residents in rooms 111 and 109, confirmed the extender commode seat was not to be stored on the floor.	F 441		